

10876
Reg. Dist. No. 185-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u> <u>P.O.H.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Harford</u> CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Bel Air Rural</u> STREET ADDRESS (If rural, give location) <u>Harford Terrace</u>	
3. NAME OF DECEASED: (Type or Print) (First) <u>HERMAN</u> (Middle) <u>EUGENE</u> (Last) <u>ADAMS</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>25</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec 5th 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Gravel Industry</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Lester Adams</u>		14. MOTHER'S MAIDEN NAME: <u>Zollie Higgins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>215-16-6331</u>	
17. INFORMANT & ADDRESS: <u>Mrs Herman E Adams Bel Air Rural Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Myocardial infarct</u> <u>DUE TO coronary occlusion</u> Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>3/2</u>		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>William Wood</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/25/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>Nov 20th 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>Bel Air Memorial Gardens</u>	LOCATION (City, town, or county) (State): <u>Bel Air Harford Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Nov. 26-55</u>		24. FUNERAL DIRECTOR ADDRESS: <u>John E. Herring Aberdeen Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

BUREAU V. S.

NOV 28 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10877

10877 CERTIFICATE OF DEATH

Reg. Dist. No. 185

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre-de-Grace D.O.A.</u>				TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Harford Memorial Hospital</u>				<u>Rural Delivery</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Maude</u> (Middle) <u>Akins</u> (Last) <u>Akins</u>				(Month) <u>11</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Colored</u>		<u>Child</u>		<u>7/8/50</u>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>5</u> yrs.						<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
		<u>Walter Akins</u>		<u>Viola Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Viola Akins (Mother)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>571.1</u> IMMEDIATE CAUSE (A) <u>Left side dilatating heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute hemorrhagic enteritis</u>				<u>1 day</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Intestinal enteritis</u>				<u>3 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/4/55</u>, 19<u>55</u>, to <u>11/4/55</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/4/55</u>, 19<u>55</u>, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sam Wehbert M.D.</u>				ADDRESS (Street, city, town, state) <u>Harre-de-Grace Md.</u>			
DATE THEREOF <u>11-9-55</u>				DATE SIGNED <u>11/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>Union Methodist</u>		<u>Aberdeen Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov 9-1955</u>		<u>G. L. Lewis M.D.</u>		<u>Charles J. Bullock</u>		<u>Harre-de-Grace Md.</u>	

1955

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

MARYLAND

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF DEPUTY SHERIFF

17. SIGNATURE OF CONSTABLE

18. SIGNATURE OF JAILER

19. SIGNATURE OF WARDEN

20. SIGNATURE OF CHIEF OF POLICE

21. SIGNATURE OF DEPUTY CHIEF OF POLICE

22. SIGNATURE OF SQUAD LEADER

23. SIGNATURE OF OFFICER

24. SIGNATURE OF DETECTIVE

25. SIGNATURE OF INVESTIGATOR

26. SIGNATURE OF RECORDS MANAGER

27. SIGNATURE OF CLERK

28. SIGNATURE OF SHERIFF

BUREAU V. E.

NOV 10 1955

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10896 CERTIFICATE OF DEATH

Reg. Dist. No. 182.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY HARFORD		MARYLAND		STATE MD.		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN RURAL-DARLINGTON		29 yrs.		TOWN RURAL-DARLINGTON X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				U.S. ROUTE #1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
ALBERT HERVEY ASHTON				Nov. 12, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	MARRIED	MAR. 11, 1883	72 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
FARMER		AGRI.		COLUMBUS, OHIO		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
RICHARD ASHTON				ELIZA McGREW			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
3 No		219-07-2514		NINA R. ASHTON, DARLINGTON, MD.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
434.1							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) DUE TO acute Congestive Heart Failure						unusual	
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
A Leukemic Leukemia							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from Nov. 11, 1955 , to Nov. 12, 1955 , that I last saw the deceased alive on Nov. 11, 1955 , and that death occurred at 1145 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Malcolm Shudley Phillips M.D.		Darlington Md		11/14/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		Nov. 16, 1955		DARLINGTON		DARLINGTON, MD.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
11-16-55		Rosella Lowndes		JOHN H. HARKINS, DELTA, PA.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-56 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10874 CERTIFICATE OF DEATH

10879

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
24 <u>HAURE de GRACE</u>		<u>19 days</u>		<u>Edgewood</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>Harford Memorial Hosp.</u>				<u>Box 177</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALBERT</u> (Middle) <u>BAIR</u> (Last)				<u>11</u> <u>27</u> <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>male</u>		<u>white</u>		<u>widowed</u>		<u>April 11 1897</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		IF UNDER 1 YEAR	
<u>Track Foreman</u>		<u>Penna. Railroad</u>		<u>58</u> yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>PENNA</u>				<u>U.S.A</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN BAIR</u>				<u>MARY DOWLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>717-07-5430</u>		<u>John T. Bair, Edgewood R.D. Maryland.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion with myocardial infarction - posterior</u>						<u>2 days.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						<u>several yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic bronchitis and Upper Respiratory Infection</u>						<u>not certain</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<input type="checkbox"/>		<u>420 N. Union Ave., Harre de Grace, Ind.</u>		<u>Nov 9th, 1955</u>		<u>Nov 27th, 1955</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>Nov 27th 1955</u>		<u>3:12 AM</u>					
22. I hereby certify that I attended the deceased from <u>Nov 9th, 1955</u> to <u>Nov 27th, 1955</u> that I last saw the deceased alive on <u>Nov 27th, 1955</u> and that death occurred at <u>3:12 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Edward E. Brown</u>		<u>420 N. Union Ave., Harre de Grace, Ind.</u>		<u>11/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 29, 1955</u>		<u>Bel Air Memorial Gardens</u>		<u>Bel Air, Harford, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Nov. 28-55</u>		<u>G. A. Lewis M.D.</u>		<u>Howard K. McComas & Son, Abingdon, Md.</u>			

NOV 29 1955

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1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10897 CERTIFICATE OF DEATH

10880

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Air, Rural		LENGTH OF STAY (in this place) 2 wks.,		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewood, Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Convalescing Home				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print) (First) George (Middle) Frederick (Last) Bangelsdorf				4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1955			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Oct. 17, 1878	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home construction		11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bangelsdorf				14. MOTHER'S MAIDEN NAME Elizabeth Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 219-16-9741		17. INFORMANT & ADDRESS Harry Bangelsdorf, Edgewood, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE (Massive)						?	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Chr. Hypertensive Cardio-Vascular Disease							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. Nov. 8, 1955		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 8, 1955 , to Nov. 15, 1955 , that I last saw the deceased alive on Nov. 15, 1955 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
SIGNATURE Willard P. Hudson				ADDRESS (Street, city, town, state) M.D. Forest HILL, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/17/55		NAME OF CEMETERY OR CREMATORY Trinity Lutheran		LOCATION (City, town, or county) (State) Joppa, Harford, Md.	
24. REC'D BY REGISTRAR 11-17-55		REGISTRAR'S SIGNATURE Russella Lowwood		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & son, Abingdon, Md.			

10880

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10880 CERTIFICATE OF DEATH

NAME: **JOHN A. WOOD**
AGE: **35**
SEX: **M**
RACE: **W**
DATE OF BIRTH: **1910**
PLACE OF BIRTH: **MD**
CITY: **BALTIMORE**
COUNTY: **MD**
MARRIED: **Y**
OCCUPATION: **DRIVER**
CAUSE OF DEATH: **HEART DISEASE**
PLACE OF DEATH: **HOME**
DATE OF DEATH: **1945**
SIGNATURE: **[Signature]**
REGISTRATION NO: **10880**

DATE OF DEATH: **1945**
PLACE OF DEATH: **HOME**
CAUSE OF DEATH: **HEART DISEASE**
MANNER OF DEATH: **NATURAL**
REGISTRATION NO: **10880**

DATE OF DEATH: **1945**
PLACE OF DEATH: **HOME**
CAUSE OF DEATH: **HEART DISEASE**
MANNER OF DEATH: **NATURAL**
REGISTRATION NO: **10880**

DATE OF DEATH: **1945**
PLACE OF DEATH: **HOME**
CAUSE OF DEATH: **HEART DISEASE**
MANNER OF DEATH: **NATURAL**
REGISTRATION NO: **10880**

DATE OF DEATH: **1945**
PLACE OF DEATH: **HOME**
CAUSE OF DEATH: **HEART DISEASE**
MANNER OF DEATH: **NATURAL**
REGISTRATION NO: **10880**

DATE OF DEATH: **1945**
PLACE OF DEATH: **HOME**
CAUSE OF DEATH: **HEART DISEASE**
MANNER OF DEATH: **NATURAL**
REGISTRATION NO: **10880**

DATE OF DEATH: **1945**
PLACE OF DEATH: **HOME**
CAUSE OF DEATH: **HEART DISEASE**
MANNER OF DEATH: **NATURAL**
REGISTRATION NO: **10880**

BUREAU V. 2

NOV 18 1945

RECEIVED

10898 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Holby</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Town Grove Pa Rural</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>Town Grove Pa R. d. 0.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Nannie</u>	(Middle) <u>Barton</u>	(Last) <u>Barton</u>	(Month) <u>Nov</u> (Day) <u>19</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Feb 24, 1881</u>
9. AGE last birthday: <u>74</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Holby md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joshua Barton</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Ann Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Rosa Barton Baltimore md</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>40 days</u>
Antecedent causes (s) (b) <u>arteria sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 15, 1955</u> , to <u>Nov 19, 1955</u> that I last saw the deceased alive on <u>Nov 19, 1955</u> and that death occurred at <u>2:45 pm</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Edward H. Tyson M.D.</u>		DATE SIGNED <u>Nov 21, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>Nov 22, 1955</u>		LOCATION (City, town, or county) (State) <u>Town Grove Pa</u>	
DATE REG'D BY LOCAL REGISTRAR <u>12-16-55</u>		REGISTRAR'S SIGNATURE <u>Prunilla Foxwood</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Howard Webb Town Grove Pa</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10875 CERTIFICATE OF DEATH

10881

Reg. Dist. No. 152

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
32 TOWN <u>Bel-Air</u>		24 yrs.		32 TOWN <u>Bel-Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>203 Archer Street</u>				STREET ADDRESS (If rural give location) <u>203 Archer Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MOLLIE E. BOND</u>				<u>Nov., 23 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<u>Female</u>	<u>Negro</u>	<u>Widowed</u>	<u>10-31-1869</u>		<u>86 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Harford Co. Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James O. Preston</u>				<u>Mary E. Jarrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>—</u>		<u>—</u>		<u>203 Archer Street</u> <u>Mrs. Rose Young - Bel-Air, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170X IMMEDIATE CAUSE (A) <u>METASTATIC CARCINOMA OF LUNGS</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>18 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>CARCINOMA OF RT. BREAST (primary site)</u>						<u>5 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>June 1952</u>		<u>Scirrhus Carcinoma breast (simple amputation)</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1952</u>, 19....., to <u>Nov. 23</u>, 1955....., that I last saw the deceased alive on <u>Nov. 23</u>, 1955....., and that death occurred at <u>5:30 PM</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Willard P. Hudson</u>				<u>11-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-27-55</u>		<u>Fairview Cemetery</u>		<u>Fairview Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11-26-55</u>		<u>Muriella Lowwood</u>		<u>Otelia J. Bullock, Hanes & Gray, Inc.</u>			

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DEATH CERTIFICATE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME

6. PLACE

7. CAUSE

8. MANNER

9. SIGNATURE

10. SIGNATURE

11. SIGNATURE

12. SIGNATURE

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86. SIGNATURE

87. SIGNATURE

BUREAU V. S.

NOV 29 1955

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10876

CERTIFICATE OF DEATH

10882

Item 12, Film G190 12-13-55 et

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harrede-Grace</u>		<u>4 months</u>		TOWN <u>Port Deposit</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Old Mill 1777</u>			
3. NAME OF DECEASED (Type or Print) <u>Patsy Pasquale Bosco</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>? - 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Dominick Bosco</u>				14. MOTHER'S MAIDEN NAME <u>Tersse Chiffolini</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
141X IMMEDIATE CAUSE (A) <u>Cancer tongue & throat</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Some</u> , 19 <u>52</u> , to <u>11-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-26</u> , 19 <u>55</u> , and that death occurred at <u>8:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Port Deposit Cecil Md</u>			
DATE <u>Nov. 29-1955</u>				DATE SIGNED <u>11-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Not known</u>		LOCATION (City, town, or county) (State) <u>Harford Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Harford Md</u>	

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10883

10899 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>RURAL HARREDEGRACE</u>	
X TOWN <u>RURAL HARREDEGRACE</u>		<u>LIFE</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>HOME</u>		STREET ADDRESS		<u>HOME</u>	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALEXANDER THEODORE BRADFORD</u>				<u>NOV. 25, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>AUG. 9, 1882</u>	<u>73</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>		<u>TENNAAT FARMER</u>		<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>GEO. W. BRADFORD</u>				<u>ROSE FRENCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>9 -</u>		<u>-</u>		<u>MRS. DEBORAH B. BRADFORD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
181X IMMEDIATE CAUSE (A)				<u>Carcinoma of Bladder</u>		<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B)			
STATING UNDERLYING CAUSE LAST.				DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>NOV 1, 1955</u> , to <u>NOV 25, 1955</u> , that I last saw the deceased alive on <u>NOV 23, 1955</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Dudley Plulley, Jr.</u>				<u>11/26/55</u>		<u>MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOV. 28 '55</u>		<u>WESLEYAN CHAPEL</u>		<u>HARFORD MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>NOV. 28.</u>		<u>Bertha B. Knight</u>		<u>R. Madison Mitchell</u>		<u>HARFORD MD.</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED

MR. HENRY DE GRACE

RESIDENCE

HOME

ALEXANDER THEODORE BRADFORD

MARRIED APR. 9, 1882

DECEASED AT HOME

JOSE FRENCH

GRACE W. BRADFORD

MRS. DEBORAH A. BRADFORD

BUREAU V. S.

DEC 5 1935

RECEIVED

NOTES: WESTERN CHURCH

DECEASED

MR. HENRY DE GRACE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10877

CERTIFICATE OF DEATH

10884

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Aberdeen</i>				TOWN <i>Aberdeen</i>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Street</i>				STREET ADDRESS (If rural give location) <i>Washington Street</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Minnie</i> (Middle) <i>Levina</i> (Last) <i>Brown</i>				(Month) <i>Nov</i> (Day) <i>6th</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb. 5th 1886</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Samuel Giles Brown Sr.</i>				14. MOTHER'S MARDEN NAME <i>Levina Gilbert</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Edna Pair, #607 Jersey Ave. Aberdeen Md.</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>			
ANTECEDENT CAUSE(S) DUE TO <i>Nephrosclerosis</i>				<i>1 yr.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hypertensive Heart Disease</i>				<i>7 yr</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-8</i> , 19 <i>55</i> , to <i>11-6-55</i> , that I last saw the deceased alive on <i>11-5-55</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.							
SIGNATURE <i>John W. Rohman, M.D.</i>				ADDRESS (Street, city, town, state) <i>#8 Law St. Aberdeen, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Nov. 9th</i>		NAME OF CEMETERY OR CREMATORY <i>Union W. & Cemetery</i>		LOCATION (City, town, or county) (State) <i>Aberdeen Rural. Md.</i>	
24. REC'D BY REGISTRAR <i>Nov. 9-55</i>		REGISTRAR'S SIGNATURE <i>Hellie R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Sarring</i>		ADDRESS <i>Aberdeen Md.</i>	

CERTIFICATE OF DEATH

DATE OF DEATH

LOCAL HEALTH OFFICE OR COUNTY

NAME OF DECEASED

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

NOV 14 1955

RECEIVED

ENCLOSURE

PROPERTY OF

DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10878
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10885
Reg. Dist. No. 185

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u> <u>Harpard</u> MARYLAND		STATE <u>Pa.</u> COUNTY		CITY (If outside corporate limits write RURAL and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>1 mi. north Port Deposit</u> <u>D.O.A.</u>		LENGTH OF STAY (in this place)		TOWN <u>Philadelphia</u> <u>75 x 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Webster's Tavern</u>				STREET ADDRESS (If rural, give location) <u>1635 North Dover Street</u>			
3. NAME OF DECEASED: (First) <u>CLAUDE</u>		(Middle) <u>ROOSEVELT</u>		(Last) <u>BRYANT</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>29</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12/18/05</u>	9. AGE last birthday: <u>50</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>General Fund</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>		11. BIRTHPLACE (State or foreign country): <u>St. Marys Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Wm. C. Bryant</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Mary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Wm. C. Bryant 2443 W. Oxford St. Phila. Pa.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>stab wound of heart</u> <u>MECH</u> Antecedent cause(s) (b) <u>Massive pericardial hemorrhage</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>11/29/55</u>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Tavern</u>		21c. (City or town) (County) (State) <u>Port Deposit Cecil Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11/29/55 9:15 PM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>altercation. Stabbed with ice pick during</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William V. Smith</u>		M. D. ASSISTANT MEDICAL EXAM. <u>11/30/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>buried</u>		DATE THEREOF: <u>11/30/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Unknown</u>		LOCATION (City, town, or county) (State): <u>Philadelphia Pa.</u>	
DATE REC'D BY LOCAL REG. <u>11/30-55</u>		REGISTRAR'S SIGNATURE: <u>G. L. Lewis M. D.</u>		24. FUNERAL DIRECTOR: <u>James E. Long</u>		ADDRESS: <u>212 W. Oxford Phila. Pa.</u>	

BUREAU V. S.

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10879 CERTIFICATE OF DEATH

10886

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN <u>HAVERDE GRACE</u>		LENGTH OF STAY (in this place) <u>30 yrs.</u>		CITY OR TOWN <u>HAVERDE GRACE</u>		24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>JUNITA, ST.</u>				STREET ADDRESS <u>JUNITA, ST.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>ALBERT</u> (First) <u>CARPENTER</u> (Middle) (Last)				4. DATE OF DEATH <u>Nov. 23</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>BLACK</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 27, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank.</u>				14. MOTHER'S MAIDEN NAME <u>Frank.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-2584</u>		17. INFORMANT & ADDRESS <u>ELSIE MAY CARPENTER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>HAVERDE GRACE</u>			
420.1 IMMEDIATE CAUSE (A) <u>Pulmonary Edema -</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day -</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Occlusion -</u>				<u>1 day -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Disease & Hypertrophy -</u>				<u>5 years -</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis & Hypertension</u>				<u>10 years -</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 4, 1955</u> to <u>Nov. 23, 1955</u> , that I last saw the deceased alive on <u>Nov. 23, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John Wolcott M.D.</u>				ADDRESS (Street, city, town, state) <u>John Wolcott M.D. - Nov 23, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov. 26 '55</u>		NAME OF CEMETERY OR CREMATORY <u>SKINNER'S CEM.</u>		LOCATION (City, town, or county) (State) <u>HAVERDE GRACE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. Lewis m.d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madson Mitchell</u>		ADDRESS <u>HAVERDE GRACE, MD.</u>	
DATE <u>Nov 26-1955</u>							

CERTIFICATE OF DEATH

1955

Reg. No. 100-1

1. NAME OF DECEASED

HAIR F-199 MO.

HAIR F-199 HAIR F-199

JOHN A. ST

NOV. 23 1955

MAILED FEB 21 1956

MASS. N 2 A

MASS.

219-07-2284 ELIZABETH (APPEARED)

HAIR F-199

HAIR F-199 HAIR F-199

JOHN A. ST

ALBERT

MALE BLACK

JOHN A.

MASS.

NO

BUREAU V. 3

NOV 28 1955

RECEIVED

WILLIAM W. STANLEY, HAIR F-199

ALBERT

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 19

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10900 **CERTIFICATE OF DEATH**

10887

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland COUNTY Harford		CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air R.D.		LENGTH OF STAY (in this place) lifetime	
CITY OR TOWN Bel Air R.D.		CITY OR TOWN Bel Air R.D.		STREET ADDRESS Creswell		HOSPITAL OR INSTITUTION OR STREET ADDRESS 00	
3. NAME OF DECEASED (First) Roland (Middle) W. (Last) Cullum				4. DATE OF DEATH (Month) Nov. (Day) 29 (Year) 1955			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Dec. 7, 1936	9. AGE last birthday 18 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Cullum				14. MOTHER'S MAIDEN NAME Edna M. Elliott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS James W. Cullum, Bel Air, R.D. 2 Md			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
501X IMMEDIATE CAUSE (A) Spastic Paraplegia - idiocy				INTERVAL BETWEEN ONSET AND DEATH 19 yrs			
ANTECEDENT CAUSE(S) DUE TO (B) asthma - bronchitis				10 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ascaris infestation anemias				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0 0		19b. MAJOR FINDINGS OF OPERATION 0		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 12, 1955 to Nov 29, 1955 , that I last saw the deceased alive on Nov 28, 1955 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
SIGNATURE John O'Hodous		M.D. Edgewood, Md.		ADDRESS (Street, city, town, state) Abingdon, Md.		DATE SIGNED 11-29-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 2, 1955		NAME OF CEMETERY OR CREMATORY Calvary Methodist		LOCATION (City, town, or county) Calvary, Harford, Md.	
24. REC'D BY REGISTRAR Dec 2, 1955		REGISTRAR'S SIGNATURE Norma G. Moore		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombes & Son		ADDRESS Abingdon, Md.	

CERTIFICATE OF DEATH

Form No. 120

1. USUAL RESIDENCE (NUMBER OF DOCKETS)

2. PLACE OF DEATH

3. DATE OF DEATH

4. NAME OF DECEASED

5. SEX

6. AGE

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. CAUSE OF DEATH

13. PLACE OF BIRTH

14. DATE OF BIRTH

15. SEX

16. CAUSE OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX

20. CAUSE OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. SEX

24. CAUSE OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX

28. CAUSE OF DEATH

29. PLACE OF BIRTH

30. DATE OF BIRTH

31. SEX

32. CAUSE OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. CAUSE OF DEATH

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40. CAUSE OF DEATH

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42. DATE OF BIRTH

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44. CAUSE OF DEATH

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46. DATE OF BIRTH

47. SEX

48. CAUSE OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX

52. CAUSE OF DEATH

53. PLACE OF BIRTH

54. DATE OF BIRTH

55. SEX

56. CAUSE OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX

60. CAUSE OF DEATH

61. PLACE OF BIRTH

62. DATE OF BIRTH

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64. CAUSE OF DEATH

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67. SEX

68. CAUSE OF DEATH

69. PLACE OF BIRTH

70. DATE OF BIRTH

71. SEX

72. CAUSE OF DEATH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. SEX

76. CAUSE OF DEATH

77. PLACE OF BIRTH

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BUREAU V. 8

DEC 5 1955

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BUREAU V. S.

NOV 25 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10880

CERTIFICATE OF DEATH

10889

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace 40 min</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace 24</u>	
TOWN <u>Harre-de-Grace</u>		LENGTH OF STAY (in this place) <u>40 min</u>		STREET ADDRESS (If rural give location) <u>553 Fountain ST</u>		TOWN <u>Harre-de-Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>553 Fountain ST</u>			
3. NAME OF DECEASED (Type or Print) <u>Jay</u> (First) <u>Vernon</u> (Middle) <u>Disbrow</u> (Last)				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 29 1906</u>	
9. AGE last birthday <u>48</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL GROCER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>SANFORD DISBROW</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. GRIFFITH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	
16. SOCIAL SECURITY NO. <u>216-65-3723</u>		17. INFORMANT & ADDRESS <u>Mrs. M. LYNDE DISBROW</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION <u>5-16-55</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>HARREDEGRACE MD</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>4-16-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>4-16-55</u> to <u>11-13-55</u> that I last saw the deceased alive on <u>11-13-55</u> and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.	
22. SIGNATURE <u>C. L. Lewis MD</u> M.D. <u>Harre-de-Grace MD</u>		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23. DATE THEREOF <u>11-16-1955</u>		23. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>	
24. REC'D BY REGISTRAR <u>G. L. Lewis</u>		24. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. MADISON MITCHELL</u>		25. ADDRESS <u>HARREDEGRACE MD</u>	
26. DATE <u>Nov-16-1955</u>		27. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		28. FUNERAL DIRECTOR'S SIGNATURE <u>R. MADISON MITCHELL</u>		28. ADDRESS <u>HARREDEGRACE MD</u>	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

BUREAU V. A.

NOV 18 1955

W. Madison W. Madison
14705 05340 E. A. W.
MD

11-10-1955 14705 05340 E. A. W.

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of registrar
9. Date of registration
10. Name of registrar
11. Name of hospital
12. Name of physician
13. Name of funeral home
14. Name of cemetery
15. Name of burial place
16. Name of interment place
17. Name of crematorium
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10902 CERTIFICATE OF DEATH

10890

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Aberdeen</u>		<u>1</u>		TOWN <u>Aberdeen</u>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u>				STREET ADDRESS (If rural give location)			
<u>50</u> <u>Aberdeen Proving Ground, Md.</u>				<u>266 Paradise Road,</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Harold</u> <u>Vietz</u> <u>Duppstadt</u>				<u>November 4 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>22 August 1909</u>	<u>46</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Automotive Engr</u>		<u>Army Ordnance</u>		<u>Ohio</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward L Duppstadt</u>				<u>Carrie Elea nor Dietz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>273090471</u>		<u>Civilian Personnel</u> <u>Aberdeen Proving Ground, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. <u>587.0</u> IMMEDIATE CAUSE (A) <u>Gastrointestinal hemorrhage</u>						<u>2 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute renal failure</u>						<u>11 days</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Acute hemorrhagic pancreatitis</u>						<u>16 days</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cholecystitis with cholelithiasis</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>None</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		<u>NA</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Oct</u> , 19 <u>55</u> , to <u>4 Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 Nov</u> , 19 <u>55</u> , and that death occurred at <u>1:15a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. H. Hauch</u>		ADDRESS (Street, city, town, state) <u>M.D. US Army Hospital, APG, Md.</u>		DATE SIGNED <u>4 Nov 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Removal</u>	<u>Nov. 6-1955</u>	<u>Ligonier Valley Cemetery</u>		<u>Ligonier, Pennsylvania</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
<u>Nov. 5-55</u>	<u>Mellie G. Perry</u>	<u>John G. Parving - Aberdeen road.</u>					

EXHIBIT

This exhibit is to be used for the purpose of showing the results of the investigation of the case of the death of the person named in the certificate of death. It is to be filled out by the coroner or the physician in charge of the investigation. It is to be filled out in duplicate, one copy to be filed in the office of the coroner or the physician, and the other copy to be filed in the office of the registrar of vital statistics. It is to be filled out in duplicate, one copy to be filed in the office of the coroner or the physician, and the other copy to be filed in the office of the registrar of vital statistics.

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

10280

Reg. Dist. No.

1. CORONER'S NAME AND ADDRESS

Name: _____ Address: _____

2. PHYSICIAN'S NAME AND ADDRESS

Name: _____ Address: _____

3. DEATH CERTIFICATE

Name: _____ Address: _____

4. DEATH CERTIFICATE

Name: _____ Address: _____

5. DEATH CERTIFICATE

Name: _____ Address: _____

6. DEATH CERTIFICATE

Name: _____ Address: _____

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11. DEATH CERTIFICATE

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16. DEATH CERTIFICATE

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17. DEATH CERTIFICATE

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18. DEATH CERTIFICATE

Name: _____ Address: _____

19. DEATH CERTIFICATE

Name: _____ Address: _____

20. DEATH CERTIFICATE

Name: _____ Address: _____

BUREAU V. S.

NOV 8 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10891

10903 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>		LENGTH OF STAY (in this place) <u>4 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>			
TOWN <u>ADRBISVILLE</u>				TOWN <u>ADRBISVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. ROUTE 1 STEWARTSTOWN, PENNA</u>				STREET ADDRESS (If rural give location) <u>R.F.D. ROUTE 1 STEWARTSTOWN PENNA</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>LOU</u> (Last) <u>BARVER</u>				(Month) <u>11</u> (Day) <u>19</u> (Year) <u>1935</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>12-27-1869</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEO. HECK</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA LOHMULLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, and, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>3022 WILLOUGHBY RD L. MORGAN FITZELL BALTO 14</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>12 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Advanced Arterio Sclerosis</u>						<u>20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Nov. 19</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 19 <u>53</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William D. Fulton</u> M.D.				ADDRESS (Street, city, town, state) <u>Stewartstown</u> DATE SIGNED <u>11/19/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
24. REC'D BY REGISTRAR <u>NOV 21 1955</u>		REGISTRAR'S SIGNATURE <u>Fusilla Fournier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brother Bradley</u>		ADDRESS <u>—</u>	

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2, Film G189 11-28-55 et

10881

CERTIFICATE OF DEATH

10892

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Md.		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
24 TOWN Havre De Grace		6 WEEKS		TOWN Pikesville 8, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
71 Harford Memorial Hospital				Mrs. James Watkins, 202 Clarendon Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) NEVA (Middle) LAWDER (Last) GILBERT				(Month) Nov. (Day) 14 (Year) 55		19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Fem.	Wh.	Single	Feb. 13, 1885	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired			BYD. RR. Club		BALTO. MD		U.S.A
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jarrett N. GILBERT				LYDIA LAWDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
g				Mr. Rene M. Gilbert Harford Md. R.D.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Chr. Myocardial Disease							
ANTECEDENT CAUSE(S) DUE TO (B) Chr. Hypertensive Cardio-vascular Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 53, to Nov. 14, 1955, that I last saw the deceased alive on Nov. 13, 1955, and that death occurred at 7:10 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Willard P. Hudson M.D. Forest Hill, Md.						11-15-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		11-18-1955		WESLEYAN CHAPEL		HARFORD MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Nov. 17-1955		G. L. Lewis M.D.		R. Madison Mitchell Harford Grace MD.			

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10893

10904 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bel Air (Rural)</u>		<u>20 years</u>		TOWN <u>Bel Air MD</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>Rock Spring Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NANCY</u> (Middle) <u>Charlotte</u> (Last) <u>GREER</u>				(Month) <u>Nov.</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>June 9/1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>EK Creek, Va.</u>		<u>U.S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Rudy</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>9</u>				<u>✓</u>		<u>GARLAND GREER</u> <u>Bel Air, MD</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>170X</u> IMMEDIATE CAUSE (A) <u>Carcinoma of breast</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY?	
<u>None</u>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1955</u> , 19 <u>55</u> , to <u>Nov. 1st</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>55</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Willard P. Hedden M.D.</u>				<u>Forest Hill, Md.</u>		<u>11-2-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>Nov 4/1955</u>	<u>Highland Presbyterian</u>		<u>Highland Hartford</u>		<u>MD</u>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS
<u>11-3-1955</u>	<u>Priscilla Lowwood</u>			<u>Joseph Foster Ballard</u>			<u>md</u>

10803

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1900 CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF CHURCH OFFICIAL

16. SIGNATURE OF MINISTER

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF RABBI

19. SIGNATURE OF JEWELER

20. SIGNATURE OF OPTICIAN

21. SIGNATURE OF DENTIST

22. SIGNATURE OF VETERINARIAN

23. SIGNATURE OF SURGEON

24. SIGNATURE OF PHYSICIAN

25. SIGNATURE OF NURSE

26. SIGNATURE OF MIDWIFE

27. SIGNATURE OF DOCTOR

28. SIGNATURE OF ATTORNEY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CONSTABLE

33. SIGNATURE OF JURY

34. SIGNATURE OF GRAND JURY

35. SIGNATURE OF COURT

36. SIGNATURE OF JUDGE

37. SIGNATURE OF CLERK

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF CONSTABLE

40. SIGNATURE OF JURY

41. SIGNATURE OF GRAND JURY

42. SIGNATURE OF COURT

43. SIGNATURE OF JUDGE

44. SIGNATURE OF CLERK

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF CONSTABLE

47. SIGNATURE OF JURY

48. SIGNATURE OF GRAND JURY

49. SIGNATURE OF COURT

50. SIGNATURE OF JUDGE

51. SIGNATURE OF CLERK

52. SIGNATURE OF SHERIFF

53. SIGNATURE OF CONSTABLE

54. SIGNATURE OF JURY

55. SIGNATURE OF GRAND JURY

56. SIGNATURE OF COURT

57. SIGNATURE OF JUDGE

58. SIGNATURE OF CLERK

59. SIGNATURE OF SHERIFF

60. SIGNATURE OF CONSTABLE

61. SIGNATURE OF JURY

62. SIGNATURE OF GRAND JURY

63. SIGNATURE OF COURT

64. SIGNATURE OF JUDGE

65. SIGNATURE OF CLERK

66. SIGNATURE OF SHERIFF

67. SIGNATURE OF CONSTABLE

68. SIGNATURE OF JURY

69. SIGNATURE OF GRAND JURY

70. SIGNATURE OF COURT

71. SIGNATURE OF JUDGE

72. SIGNATURE OF CLERK

73. SIGNATURE OF SHERIFF

74. SIGNATURE OF CONSTABLE

75. SIGNATURE OF JURY

76. SIGNATURE OF GRAND JURY

77. SIGNATURE OF COURT

78. SIGNATURE OF JUDGE

79. SIGNATURE OF CLERK

80. SIGNATURE OF SHERIFF

81. SIGNATURE OF CONSTABLE

82. SIGNATURE OF JURY

83. SIGNATURE OF GRAND JURY

84. SIGNATURE OF COURT

85. SIGNATURE OF JUDGE

86. SIGNATURE OF CLERK

87. SIGNATURE OF SHERIFF

88. SIGNATURE OF CONSTABLE

89. SIGNATURE OF JURY

90. SIGNATURE OF GRAND JURY

91. SIGNATURE OF COURT

92. SIGNATURE OF JUDGE

93. SIGNATURE OF CLERK

94. SIGNATURE OF SHERIFF

95. SIGNATURE OF CONSTABLE

96. SIGNATURE OF JURY

97. SIGNATURE OF GRAND JURY

98. SIGNATURE OF COURT

99. SIGNATURE OF JUDGE

100. SIGNATURE OF CLERK

101. SIGNATURE OF SHERIFF

102. SIGNATURE OF CONSTABLE

103. SIGNATURE OF JURY

104. SIGNATURE OF GRAND JURY

105. SIGNATURE OF COURT

106. SIGNATURE OF JUDGE

107. SIGNATURE OF CLERK

108. SIGNATURE OF SHERIFF

109. SIGNATURE OF CONSTABLE

110. SIGNATURE OF JURY

111. SIGNATURE OF GRAND JURY

112. SIGNATURE OF COURT

113. SIGNATURE OF JUDGE

114. SIGNATURE OF CLERK

115. SIGNATURE OF SHERIFF

116. SIGNATURE OF CONSTABLE

117. SIGNATURE OF JURY

118. SIGNATURE OF GRAND JURY

119. SIGNATURE OF COURT

120. SIGNATURE OF JUDGE

BUREAU V. S.

NOV 7 1935

RECEIVED

RECEIVED

10905

10894

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 182

1. PLACE OF DEATH:

COUNTY Hartford MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) ROCKS LENGTH OF STAY (in this place) Life
 TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Hartford
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rocks
 STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First) Earl (Middle) S (Last) Harris
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
November 4 19 55

5. SEX:

M

6. COLOR OR RACE:

601

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

SINGLE

8. DATE OF BIRTH:

July 5-1955

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.
 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Rocks, Md

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

George Harris

14. MOTHER'S MAIDEN NAME:

Ada Higgins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Ada Higgins
Rocks
Box 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

7720
 Immediate cause

(a) Malnutrition
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO
 (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

A vitaminosis

INTERVAL BETWEEN
 ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Lerald C Palmer

CHIEF MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☐
 M. D. ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

11/4/55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Nov 5/55

NAME OF CEMETERY OR CREMATORY

Rocks Church

LOCATION (City, town, or county) (State)

Rocks Hartford Md

DATE REC'D BY LOCAL REG.

11-4-55

REGISTRAR'S SIGNATURE

Priscilla Forward

24. FUNERAL DIRECTOR

Joe J. Foster Bel Air Md

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 4 1955

RECEIVED

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10882 **CERTIFICATE OF DEATH**

10895

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	STATE <i>MARYLAND</i>	COUNTY <i>Harford</i>	STATE <i>MARYLAND</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)
TOWN <i>Harford Chase</i>	<i>37 yrs.</i>	TOWN <i>Harford Chase</i>	<i>24</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)	STREET ADDRESS (If rural give location)	
		<i>716 Green</i>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>John James Heath</i>		<i>11/6/55</i> <i>19</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>5/24/1897</i>
9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days)	IF UNDER 24 HRS. (Hours) (Min.)	
<i>58</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Mechanic</i>	<i>A. T. & P.</i>	<i>Doylestown Pa.</i>	<i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John J. Heath</i>		<i>Caroline Ocourt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes give kind or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>087-10-3637</i>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<i>Mrs. June T. Heath</i> <i>716 Green</i>			
19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>4-20-1</i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>		<i>Coronary Thrombosis</i>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
<i>Harford Chase, Md.</i>		<i>11/6/55</i>	
21e. HOW DID INJURY OCCUR?		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<i>Heart Attack</i>		<i>While at work</i>	
22. I hereby certify that I attended the deceased from <i>2:10</i>, 19<i>53</i>, to <i>11/4</i>, 19<i>55</i>, that I last saw the deceased alive on <i>11/6</i>, 19<i>55</i>, and that death occurred at <i>9:15 P.</i> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>Charles J. Feltz</i>		<i>11/8/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<i>Burial</i>		<i>4. L. Lewis, Jr.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>James M. Dean</i>		<i>Harford Chase, Md.</i>	
DATE		DATE	
<i>Nov 9 1955</i>		<i>Nov 9 1955</i>	

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10883

CERTIFICATE OF DEATH

10896

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAURC de GRACE</u>		<u>2 days</u>		TOWN <u>Aberdeen</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL Hosp</u>				STREET ADDRESS (If rural give location) <u>Edmond St</u>			
3. NAME OF DECEASED (Type or Print) <u>JOHN E HUBARD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 29 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Sept 8 - 1899</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Dep't</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-4375</u>		17. INFORMANT & ADDRESS <u>Wuro Sabie Hubard Aberdeen Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
DUE TO ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertensive Cardiovascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10/1</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/1</u> , 19 <u>55</u> , to <u>11/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/29</u> , 19 <u>55</u> , and that death occurred at <u>6:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city, town, state) <u>M.D. 529 Revolution St. Harford de Grace, Md.</u>		DATE SIGNED <u>11/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wt. Pchary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Yarruig</u>		ADDRESS <u>Aberdeen Md.</u>	
DATE <u>Dec. 1 - 1965</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10883

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF CHIEF CLERK</p>		<p>18. SIGNATURE OF ASSISTANT CLERK</p>		<p>19. SIGNATURE OF DEPUTY CLERK</p>		<p>20. SIGNATURE OF CLERK</p>	

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BUREAU V. S.

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10897

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 180

1. PLACE OF DEATH: COUNTY <i>Hancock</i> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Handi Chase</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Hancock</i> CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Handi Chase</i> STREET ADDRESS (If rural, give location) <i>566 Lewis</i>	
3. NAME OF DECEASED: (Type or Print) <i>Mary</i> (First) <i>James</i> (Last)		4. DATE OF DEATH (Month) <i>November</i> (Day) <i>24</i> (Year) <i>1953</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>None</i>	8. DATE OF BIRTH: <i>5/30/1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	9. AGE last birthday: <i>77</i> yrs.
11. BIRTHPLACE (State or foreign country): <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Charles Palmer</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Single</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>James P. Jackson, Balto. 12, 1944</i>	
17. INFORMANT & ADDRESS: <i>James P. Jackson, 1404 Haddon Ave. Balto. 12, Md.</i>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <i>422.1</i> Immediate cause (a) <i>Arteriosclerotic C.V. disease</i> DUE TO Antecedent cause(s) (b) <i>None</i> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Gerald C Palmer</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <i>11/27/53</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>	DATE THEREOF: <i>11/27/53</i>	NAME OF CEMETERY OR CREMATORY: <i>St. James</i>	LOCATION (City, town, or county) (State): <i>Handi Chase, Md.</i>
DATE REC'D BY LOCAL REG. <i>Nov. 27-53</i>	REGISTRAR'S SIGNATURE: <i>G. L. Lewis M.D.</i>	24. FUNERAL DIRECTOR: <i>James P. Jackson</i> ADDRESS: <i>Handi Chase, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 29 1955

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10885 CERTIFICATE OF DEATH

10898

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>		TOWN <i>31</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>50 33 Emerson Street</i>				STREET ADDRESS <i>33 Emerson Street</i>			
3. NAME OF DECEASED (Type or Print) <i>Arthur William Jewell</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov 27th 1955</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>9/11/1955</i>	
9. AGE last birthday <i>—</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William S. Jewell, Jr.</i>				14. MOTHER'S MAIDEN NAME <i>Barbara Cook</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO. <i>Infant</i>		17. INFORMANT & ADDRESS <i>Mrs Arthur Cook #22 Post Rd. Aberdeen Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1-2 hours	
493X IMMEDIATE CAUSE (A) <i>acute infection - pneumonia</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/11, 1955, to 11/27, 1955, that I last saw the deceased alive on 11/20, 1955, and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
SIGNATURE <i>J. J. [Signature]</i>		DATE THEREOF <i>Nov 30-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Bethel Memorial Garden</i>		LOCATION (City, town, or county) <i>Bethel Maryland</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>Willie R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i>		ADDRESS <i>Aberdeen Md.</i>	

2095201416

10798

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE (HOME OR BUSINESS)

MARYLAND

2. PLACE OF DEATH

COUNTRY

STATE

CITY

STREET

APARTMENT

NAME OF

DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

REPORTED BY

SIGNATURE

DATE

TIME

PLACE

REMARKS

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

REPORTED BY

SIGNATURE

DATE

TIME

PLACE

REMARKS

III. MEDICAL CERTIFICATION

1. I AM A PHYSICIAN WHO HAS BEEN LICENSED TO PRACTICE MEDICINE IN THE STATE OF MARYLAND.

2. I HAVE EXAMINED THE BODY OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

3. I HAVE EXAMINED THE RECORDS OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

4. I HAVE EXAMINED THE RECORDS OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

5. I HAVE EXAMINED THE RECORDS OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

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18. I HAVE EXAMINED THE RECORDS OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

19. I HAVE EXAMINED THE RECORDS OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

20. I HAVE EXAMINED THE RECORDS OF THE DECEASED AND HAVE FOUND NO EVIDENCE OF DISEASE OR INJURY.

BUREAU V. S.

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NOTIFICATION

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10886

CERTIFICATE OF DEATH

10899

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>24 Harbor de Grace</i>		LENGTH OF STAY (in this place) <i>DOA</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>24 Harbor de Grace</i>			
TOWN <i>Harbor de Grace</i>				TOWN <i>Harbor de Grace</i>		<i>1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>71 Harbor Memorial Hospital</i>				STREET ADDRESS (If rural, give location) <i>101 N. Union Ave</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Ed. Lloyd LAMBERTSON</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>November 20 19 55</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>MAR. 15, 1902</i>	9. AGE last birthday <i>53</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clergyman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meth. CHURCH</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>WM. F. KRUG SR.</i>				14. MOTHER'S MAIDEN NAME <i>ELIZABETH BALSTER</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Mr. MARIE R. KRUG</i>		<i>HARBOR DE GRACE MD.</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>422.1 IMMEDIATE CAUSE (A) Coronary thrombosis</i> ANTECEDENT CAUSE(S) DUE TO <i>Cardio-vascular disease</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>—</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2-13</i> , 19 <i>55</i> , to <i>11-20</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11-22</i> , 19 <i>55</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>G. L. Lewis M.D.</i>				ADDRESS (Street, city, town, state) <i>Harbor de Grace, Md</i>		DATE SIGNED <i>11-22-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>11-23-55</i>		NAME OF CEMETERY OR CREMATORY <i>WOODSTOCK PARKWOOD</i>		LOCATION (City, town, or county) (State) <i>BALTO. CO. MD.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>R. MADISON MITCHELL</i>		ADDRESS <i>HARBOR DE GRACE MD.</i>	
DATE <i>Nov. 22-1955</i>							

Mar. 19, 1907

WILLIAM GIBSON BENTLEY

M. W. F. 11/10/20

ET. 340 ET H. B. 1721

Mr. WAB: 15. 11. 1904

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10900

10887 **CERTIFICATE OF DEATH**Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Havre De Grace</u>				TOWN <u>Port Deposit</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>78 N. Main St</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Harry James Mason</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 3 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 23, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Perry Mason</u>				14. MOTHER'S MAIDEN NAME <u>Sallie E. Dunmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-0082</u>		17. INFORMANT & ADDRESS <u>Alice M. Hughes, Port Deposit, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11/2/55</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus with Azotemia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchitis with Pleuritis</u>						<u>11/2/55</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/1</u> , 19 <u>51</u> , to <u>11/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>55</u> , and that death occurred at <u>12:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city, town, state) <u>M.D. 569 Revolution St., Havre de Grace, Md.</u>		DATE SIGNED <u>11/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR <u>Nov. 5-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>V. Lee Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	

1000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1907 CERTIFICATE OF DEATH

NAME OF DECEASED Maryland		PLACE OF DEATH Baltimore	
DATE OF DEATH May 25, 1907		CAUSE OF DEATH Cerebral Hemorrhage	
AGE 45		SEX Male	
OCCUPATION None		EDUCATION None	
MARRIAGE None		RELIGION None	
BIRTH May 25, 1860		PLACE OF BIRTH Baltimore	
FATHER John Henry Mason		MOTHER Alice K. Mason	
PREVIOUS ILLNESS None		MEDICAL ATTENDANCE None	
BURIAL None		FUNERAL None	

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Handwritten signature and notes at the bottom of the form.

Vertical text on the right margin, likely a filing or processing stamp.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10888

CERTIFICATE OF DEATH

12012

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <i>Harve de Grace</i>		<i>1 month</i>		TOWN <i>Monkton</i>		<i>1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>E.D. #1 - Box 131</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Baby Girl McCann</i>				<i>November 21 19 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>white</i>	<i>Newborn</i>	<i>11/20/55</i>	<i>12 months</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>—</i>		<i>—</i>		<i>Maryland</i>		<i>—</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Ray McCann</i>				<i>Irene Easter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>—</i>				<i>—</i>		<i>Hosp Records.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A)				<i>Respiratory failure</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Petal atelectasis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)				<i>Extreme prematurity</i>			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
<i>—</i>		<i>—</i>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>—</i>		<i>—</i>		<i>—</i>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<i>W. J. Norman</i>				<i>Harve de Grace</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Removal</i>				<i>11-21-55</i>		<i>Harford Memorial Hospital</i>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<i>—</i>				<i>—</i>		<i>—</i>	
DATE				ADDRESS			
<i>Dec. 6-1955</i>				<i>Harve de Grace Administrator</i>			

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1955

CERTIFICATE OF DEATH

MARYLENE STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. DEATH OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10906 CERTIFICATE OF DEATH

10901

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Street</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		STREET ADDRESS (If rural give location)		TOWN <u>Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary L Neal</u>				<u>Nov 15 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 15 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Harford Co, Md, U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>W. M. H. Healy</u>				14. MOTHER'S MAIDEN NAME <u>Martha Rigdon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Marshall L. Carlough</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				331X			
IMMEDIATE CAUSE (A) <u>cerebral hemorrhage</u>				due to			
ANTECEDENT CAUSE(S) (B) <u>sclerosis of the arteries</u>				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				DUE TO			
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 15</u> , 19 <u>55</u> , to <u>Nov 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>55</u> , and that death occurred at <u>11:57 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John O. Kirk</u> M.D.				DATE SIGNED <u>11/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 18 1955</u>		<u>Crescent Cem</u>		<u>Harford Co, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov 16 1955</u>		<u>C. G. Kirk</u>		<u>Ed Bailey</u>		<u>Washington Md</u>	

CERTIFICATE OF DEATH

1955

1. FULL NAME OF DECEASED

Robert Lee

Robert Lee
born 12/15/1918
at Baltimore, Md.
son of [illegible]
and [illegible]
husband of [illegible]
residing at [illegible]

BUREAU V. S.

NOV 22 1955

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INSTRUCTIONS

1. This certificate is to be filled out by the physician or other person who has attended the deceased.
2. It should be filled out as soon as possible after death.
3. It should be filled out in ink.
4. It should be filled out in the presence of the deceased's family or friends.
5. It should be filled out in the presence of the attending physician or other person who has attended the deceased.
6. It should be filled out in the presence of the attending physician or other person who has attended the deceased.
7. It should be filled out in the presence of the attending physician or other person who has attended the deceased.
8. It should be filled out in the presence of the attending physician or other person who has attended the deceased.
9. It should be filled out in the presence of the attending physician or other person who has attended the deceased.
10. It should be filled out in the presence of the attending physician or other person who has attended the deceased.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10907 CERTIFICATE OF DEATH

10902

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>STREET</u>		<u>2 Months</u>		TOWN <u>STREET</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>CRISTINE</u> (Middle) <u>MARIE</u> (Last) <u>PRESBURY</u>				<u>Nov</u> <u>22</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>Col</u>	<u>SINGLE</u>	<u>Sept 14 1955</u>	<u>2 Months</u>	<u>2</u> Months	<u>2</u> Days	<u>2</u> Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>✓</u>		<u>✓</u>		<u>HARPER GRACE MD</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES PRESBURY</u>				<u>DOROTHY RICE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>✓</u>		<u>✓</u>		<u>CHARLES PRESBURY</u> <u>STREET, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A)						Peripheral Vascular Collapse	
ANTECEDENT CAUSE(S) DUE TO (B)						Ac Capillary Bronchitis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>8</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 14 1955</u> to <u>Nov 22 1955</u> , that I last saw the deceased alive on <u>Nov 17 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Willard P. Hudson</u>		<u>Nov 23 55</u>		<u>Fair View</u>		<u>FOREST HILL HARTFORD MD</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>BURIAL</u>		<u>Prueella Lowndes</u>		<u>Joseph T. Tate</u>		<u>Bellan Md</u>	
DATE <u>11-23-55</u>							

2095233312

10003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. PLACE OF INTERMENT

13. MEDICAL CERTIFICATE

BUREAU V. S.

NOV 22 1955

RECEIVED

ENCLOSURE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. ONLY. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS THE RESPONSIBILITY OF THE DECEASED TO PROVIDE A TRUE AND CORRECT STATEMENT OF FACTS. IT IS THE RESPONSIBILITY OF THE DECEASED TO PROVIDE A TRUE AND CORRECT STATEMENT OF FACTS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10908
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10903
Reg. Dist.

No. 187

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Whiteford Rural</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Chesapeake</u>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7631 E Whiteford Road.</u>				STREET ADDRESS (If rural, give location) <u>113 Law Street.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Dorsey</u>	(Middle) <u>E</u>	(Last) <u>Purnell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>November 29 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 12 - 1903</u>		9. AGE last birthday: <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Refug. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Edward Purnell</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Martha Poe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Glenn Trautz 118 Law St Chesapeake Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>11/29/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF: <u>12/1/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Oakland Cemetery</u>		LOCATION (City, town, or county) (State): <u>Chesapeake Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 30 - 55</u>		REGISTRAR'S SIGNATURE: <u>Miss Paula Lewis</u>		24. FUNERAL DIRECTOR: <u>John G. Harring</u>		ADDRESS: <u>Chesapeake Md.</u>	

RECEIVED

DEC 5 1955

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10904

10889

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

Items 5-9: Filed 12/2/55 - 2/3/56

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>12X-2</u>	
CITY OR TOWN <u>Harford</u>		LENGTH OF STAY (In this place) <u>16 days</u>		STREET ADDRESS <u>Route # 2</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Richard</u> <u>Rasnake</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 29</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pay Lathery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various works</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERMAN Rasnake</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Herman Rasnake Aberdeen #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
612X IMMEDIATE CAUSE (A) <u>PULMONARY EMBOLISM</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>POST-OPERATIVE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>PROSTATECTOMY</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11-22-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>VERY LARGE PROSTATE</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 12</u> , 19 <u>55</u> , to <u>Nov. 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-28</u> , 19 <u>55</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M.C. Finney</u>				DATE SIGNED <u>11-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Park, Bel Air Maryland</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>A. L. Lewis</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>		ADDRESS <u>Aberdeen Md.</u>	
DATE <u>Dec 1-1955</u>							

INSTRUCTIONS

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VS A15C 1-55 10M

10239 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

10239

7521 12-1-55

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

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77. SIGNATURE OF DECEASED

78. SIGNATURE OF DECEASED

BUREAU V. S.

DEC 2 1955

RECEIVED

PHOTOGRAPH

DATE OF BIRTH OF DECEASED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10905

10909 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cocktown</u>		<u>62 yrs</u>		TOWN <u>Rigdon Rd Cocktown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
				<u>Rocks Rd</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HENRY</u> <u>RIGDON</u>				<u>Nov. 1st</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct. 18, 1893</u>		<u>62</u>	<u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer, Dealer, General</u>		<u>Cocktown Md</u>		<u>Md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George B. Rigdon</u>				<u>Sallie Amos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>— ?</u>		<u>Mrs Margaret B. Rigdon</u> <u>Rocks Rd</u>			
18. MEDICAL CERTIFICATION				19. INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>3 hrs.</u>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST: (B) <u>Chr. coronary artery disease</u>				<u>?</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1, 1955</u>, to <u>Nov. 1, 1955</u>, that I last saw the deceased alive on <u>Nov. 1, 1955</u>, and that death occurred at <u>4:12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u>				DATE SIGNED <u>11-2-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 9-55</u>		<u>Wm. Walters Methn</u>		<u>Cocktown Hartford Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11-4-55</u>		<u>Priscilla Lowwood</u>		<u>Martin S. Smith</u>		<u>Sancti...</u>	

Burial
 Nov 2. 1902. Wm. Walter Thomas Co. of the same name
 Burial

BUREAU V. S.

Mrs. Margaret E. Riden
 George B. Riden
 George B. Riden, General Inspector
 Mrs. Margaret E. Riden

George B. Riden
 George B. Riden, General Inspector
 Mrs. Margaret E. Riden

George B. Riden
 George B. Riden, General Inspector
 Mrs. Margaret E. Riden

George B. Riden
 George B. Riden, General Inspector
 Mrs. Margaret E. Riden

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE

1902

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10890

CERTIFICATE OF DEATH

10906

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY HARFORD		STATE Md.		COUNTY HARFORD			
CITY (If outside corporate limits, write RURAL and give nearest town) Harford		LENGTH OF STAY (In this place) Entire life		CITY (If outside corporate limits, write RURAL and give nearest town) Rural--Forest Hill, Md			
TOWN Rural--Forest Hill				TOWN Rural--Forest Hill, Md			
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD MEMORIAL Hospital				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (First) MAUD (Middle) L (Last) ROBINSON				4. DATE OF DEATH (Month) November (Day) 5, (Year) 1955			
5. SEX Fem	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH July 27, 1890	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY /		11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frank Grafton				14. MOTHER'S MAIDEN NAME Lavinia Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs Paul Peak, Forest Hill, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) Peripheral Vascular Collapse and Terminal Pneumonia						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Chr. Cardio-vascular Disease						10 Yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Chr. Essential Hypertension						15 yrs ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION /		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from May 10, 1938 , to Nov. 5, 1955 , that I last saw the deceased alive on 11-5-55 , 19....., and that death occurred at 1:00 a.m., from the causes and on the date stated above.							
SIGNATURE Willard P. Hudson M.D. Forest Hill, Md				ADDRESS (Street, city, town, state) 11-5-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov 7/55		NAME OF CEMETERY OR CREMATORY Center Methodist		LOCATION (City, town, or county) Forest Hill Harford Md (State)	
24. REC'D BY REGISTRAR Nov 9-1955		REGISTRAR'S SIGNATURE A. L. Lewis m. d.		25. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Ester Bellin m. d.		ADDRESS	

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10910 CERTIFICATE OF DEATH

10907

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Belair</u>				TOWN <u>Baltimore</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescing Home</u>				STREET ADDRESS (If rural give location) <u>6315 Hudson Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY E. SCOTT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 7, 1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 25, 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Virginia Hershey, 3593 Shannon Dr.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Lobar (hypostatic) Pneumonia (terminal)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Chr. hypertensive cardio-vascular disease</u>				?			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from..... <u>July 3</u>, 195 <u>1</u>, to..... <u>Nov. 7</u>, 195 <u>5</u>, that I last saw the deceased alive on..... <u>Nov. 7</u>, 19 <u>55</u>, and that death occurred at..... <u>11:15 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Willard R. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>11-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>11/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Townsend</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	
DATE <u>Nov. 14, 1955</u>							

BUREAU V. S.

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RECEIVED

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10911 CERTIFICATE OF DEATH

10908

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>H Arford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>24</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEAR Bel Air</u>		LENGTH OF STAY (in this place) <u>4 weeks</u>		STREET ADDRESS (If rural give location) <u>607 Pearl Street</u>		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nursing Home</u>				STREET ADDRESS (If rural give location) <u>607 Pearl Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>NICOLA</u> <u>SERPENTINO</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 25,</u> <u>1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>12/27/ 1878</u>	
9. AGE last birthday <u>76</u> yrs.		10. AGE last birthday <u>76</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Calliva Serpentino</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>217-03-0884</u>		17. INFORMANT & ADDRESS <u>Archille Sarvino, 607 Pearl St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE (2nd episode)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardio-vascular disease</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 4</u> , 19 <u>55</u> , to <u>Nov. 25,</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 25</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.		SIGNATURE <u>Willard P. Hudson</u> M.D. Forest Hill, Md.		DATE SIGNED <u>11-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/28/1955</u>		NAME OF CEMETERY OR CREMATORY <u>MT. ERIN</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, Md</u>	
24. REC'D BY REGISTRAR <u>11-28-55</u>		REGISTRAR'S SIGNATURE <u>Prucilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Son</u>			

10891 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
32 TOWN <u>BEL AIR, Md.</u>		2 yrs.		32 TOWN <u>BEL AIR.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
116 WILLIAMS ST.				116 WILLIAMS ST.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>ROBERT KIMBLE SOUTER</u>				<u>NOV. 18 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	M	JULY 2, 1916	39 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SCIENTIST		Aeronautics		PENNSYLVANIA		USA.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ROBERT WILLIAM SOUTER</u>				<u>BERTHA KIMBLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes Yes		WW II		066-14-8919		Marjorie Souter (wife) same address	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A)				<u>CARCINOMA of Rectum with widespread metastases</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 13</u> , 19 <u>55</u> , to <u>Nov. 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>55</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Paul H. Stonish Jr.</u>				<u>Nov. 18, 1955</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>11-22-55</u>		<u>Laurel Grove</u>		<u>Patterson NG</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-19-55</u>		<u>Priscilla Lowndes</u>		<u>Joseph T. Foster</u>		<u>Bel Air Md</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10912 CERTIFICATE OF DEATH

10910

Item 8, FilmG190 12-16-55 et

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Abertdeen Rural.</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Abertdeen Rural.</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>near Parsons Rure.</i>				STREET ADDRESS (If rural give location) <i>near Parsons Rure.</i>		1	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Mary J. Stansbury</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov 16th 1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Pofoed</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Oct. 22 - 11/8/77</i>	9. AGE last birthday <i>84</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. P.H.</i>				14. MOTHER'S MAIDEN NAME <i>Mary J. Harris.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Lucie H. Warfield Abertdeen Rd. #1</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
150X IMMEDIATE CAUSE (A) <i>Carcinoma of Esophagus</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arteriosclerotic Heart disease</i>							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/24</i> , 19 <i>54</i> , to <i>11/16</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11/15</i> , 19 <i>55</i> , and that death occurred at <i>8:30p</i> M., from the causes and on the date stated above.							
SIGNATURE <i>George J. Stansbury</i>				ADDRESS (Street, city, town, state) <i>M.D. 54 Revolution St. Havre de Grace, Md.</i>		DATE SIGNED <i>11/18/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11/19/55</i>		NAME OF CEMETERY OR CREMATORY <i>Union M. & Cemetery</i>		LOCATION (City, town, or county) (State) <i>Abertdeen Rural. Md.</i>	
24. REC'D BY REGISTRAR <i>Nov. 18-55</i>		REGISTRAR'S SIGNATURE <i>Hellie R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring.</i>		ADDRESS <i>Abertdeen Md.</i>	

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JAN 21 1955
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

1. USUAL RESIDENCE (HOME) OF DECEASED

2. PLACE OF DEATH

MARYLAND

COUNTY

3. USUAL RESIDENCE (HOME) OF DECEASED
 4. DATE OF DEATH
 5. TIME OF DEATH
 6. PLACE OF DEATH
 7. CAUSE OF DEATH
 8. MANNER OF DEATH
 9. SEX OF DECEASED
 10. AGE OF DECEASED
 11. OCCUPATION OF DECEASED
 12. EDUCATION OF DECEASED
 13. MARITAL STATUS OF DECEASED
 14. PREVIOUS MARRIAGES
 15. PREVIOUS DEATHS
 16. PREVIOUS DISEASES
 17. PREVIOUS SURGERIES
 18. PREVIOUS TRAUMAS
 19. PREVIOUS ACCIDENTS
 20. PREVIOUS DRUGS
 21. PREVIOUS ALCOHOL
 22. PREVIOUS TOBACCO
 23. PREVIOUS OTHER

1. USUAL RESIDENCE (HOME) OF DECEASED
 2. PLACE OF DEATH
 3. DATE OF DEATH
 4. TIME OF DEATH
 5. PLACE OF DEATH
 6. CAUSE OF DEATH
 7. MANNER OF DEATH
 8. SEX OF DECEASED
 9. AGE OF DECEASED
 10. OCCUPATION OF DECEASED
 11. EDUCATION OF DECEASED
 12. MARITAL STATUS OF DECEASED
 13. PREVIOUS MARRIAGES
 14. PREVIOUS DEATHS
 15. PREVIOUS DISEASES
 16. PREVIOUS SURGERIES
 17. PREVIOUS TRAUMAS
 18. PREVIOUS ACCIDENTS
 19. PREVIOUS DRUGS
 20. PREVIOUS ALCOHOL
 21. PREVIOUS TOBACCO
 22. PREVIOUS OTHER

18. MEDICAL CERTIFICATION

19. SIGNATURE OF PHYSICIAN

BUREAU V. S.

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10892 CERTIFICATE OF DEATH

10911

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>31 Aberdeen</u>		LENGTH OF STAY (in this place) <u>—</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>31 Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 #214 Paradise Rd.</u>				STREET ADDRESS (If rural give location) <u>#214 Paradise Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles Le Roy Stephens</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 16th 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 16th 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Utilities former retired U.S. Ent. A.P.P.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Ent. A.P.P.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Wm Ross Stephens</u>			
14. MOTHER'S MAIDEN NAME <u>Eva Jane Kilgore</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-24-7271</u>				17. INFORMANT & ADDRESS <u>Wm Charles S. Stephens Aberdeen Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unseen</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Nov 15, 1955</u>				19b. MAJOR FINDINGS OF OPERATION <u>Acute Coronary Thrombosis</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 15, 1955</u> , to <u>Nov 16, 1955</u> , that I last saw the deceased <u>alive on Nov 15, 1955</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Phillip T. W. Warrington</u>				DATE SIGNED <u>11/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>Nov 18-55</u>			
DATE THEREOF <u>11/19/55</u>				NAME OF CEMETERY OR CREMATORY <u>Salem Meth. Cemetery</u>			
LOCATION (City, town, or county) <u>Getta, R.F. York Co. Penna.</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Warrington</u>			
REGISTRAR'S SIGNATURE <u>Hellie P Perry</u>				ADDRESS <u>Aberdeen Md.</u>			

1900S CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE (HOME) OF DECEASED

PLACE OF DEATH

MARYLAND

COUNTY OF

TOWN OF

WARD OF

STREET

APARTMENT

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

DECEASED'S NAME

DECEASED'S SEX

DECEASED'S AGE

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S RACE

DECEASED'S RELIGION

DECEASED'S EDUCATION

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S BIRTH TIME

DECEASED'S BIRTH PLACE

DECEASED'S BIRTH TIME

DECEASED'S BIRTH PLACE

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DECEASED'S BIRTH TIME

BUREAU V. S.

NOV 21 1955

RECEIVED

EXHIBIT

EXHIBIT

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10893 **CERTIFICATE OF DEATH**

10912

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harveyside Grace</u>				TOWN <u>Bel Air</u>		32	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>Hartford Memorial Hospital</u>				<u>Bel Air</u>		1	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Boy Thompson</u>				<u>November 28 53</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Newborn</u>	<u>11/25/53</u>	<u>23 hours</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Milton Hubert Thompson</u>				<u>Kathleen Pickle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Hosp Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>25 HRS</u>	
762.5 IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ATELECTASIS AND/OR HYALINE MEMBRANE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>EXTREME PREMATUREITY (BIRTH WT 2'9")</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>B. B. Bennett M.D.</u>				ADDRESS (Street, city, town, state) <u>Kaurica Grace</u>		DATE SIGNED <u>11-26-53</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOR. 27/53</u>		<u>MT. OLIVE CEMETERY</u>		<u>FAWA TWP. YORK CO. PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 27-53</u>		<u>G. L. Lewis M.D.</u>		<u>John H. Harkins</u>		<u>Delta Pa.</u>	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10914

10894 CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
24 TOWN <u>Havre de Grace</u>		1 Month		24 TOWN <u>Havre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>Harford Memorial Hospital</u>				<u>Havre de Grace Heights</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Benjamin</u> (Middle) <u>C</u> (Last) <u>Wales</u>				(Month) <u>Nov.</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	C	Single	<u>Aug 29 1878</u>	75 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Truck Driver</u>		<u>Pa</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm J Wales</u>				<u>Marion H. Wales</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>104-12-7004</u>		<u>Wm J Wales, 2007</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>generalized Arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 11, 1955</u> to <u>Nov 17, 1955</u> , that I last saw the deceased alive on <u>Nov 17, 1955</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm J. Wadsworth</u> M.D.				DATE SIGNED <u>11/17/55</u>			
ADDRESS (Street, city, town, state)							
<u>Wm J. Wadsworth, 1417 1/2 St</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Interment</u>		<u>Nov 19, 1955</u>		<u>St. John's Church</u>		<u>Harford Co, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Wm J. Wadsworth</u>		<u>Wm J. Wadsworth</u>		<u>Harford Co, Md</u>	
DATE <u>Nov. 19 - 1955</u>							

10014

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10014 CERTIFICATE OF DEATH

AT MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. MARITAL STATUS

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF NEXT OF KIN

22. SIGNATURE OF CLERGYMAN

23. SIGNATURE OF BURIAL OFFICIAL

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF DECEASED

26. SIGNATURE OF NEXT OF KIN

27. SIGNATURE OF CLERGYMAN

28. SIGNATURE OF BURIAL OFFICIAL

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF DECEASED

31. SIGNATURE OF NEXT OF KIN

32. SIGNATURE OF CLERGYMAN

33. SIGNATURE OF BURIAL OFFICIAL

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF DECEASED

36. SIGNATURE OF NEXT OF KIN

37. SIGNATURE OF CLERGYMAN

38. SIGNATURE OF BURIAL OFFICIAL

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF DECEASED

41. SIGNATURE OF NEXT OF KIN

42. SIGNATURE OF CLERGYMAN

43. SIGNATURE OF BURIAL OFFICIAL

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF DECEASED

SHORT STATEMENT

1. NAME OF DECEASED
2. SEX
3. AGE
4. OCCUPATION
5. MARITAL STATUS
6. PLACE OF BIRTH
7. DATE OF DEATH
8. TIME OF DEATH
9. CAUSE OF DEATH
10. MANNER OF DEATH
11. PLACE OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESSES
15. SIGNATURE OF DECEASED
16. SIGNATURE OF NEXT OF KIN
17. SIGNATURE OF CLERGYMAN
18. SIGNATURE OF BURIAL OFFICIAL
19. SIGNATURE OF INTERVIEWER
20. SIGNATURE OF DECEASED
21. SIGNATURE OF NEXT OF KIN
22. SIGNATURE OF CLERGYMAN
23. SIGNATURE OF BURIAL OFFICIAL
24. SIGNATURE OF INTERVIEWER
25. SIGNATURE OF DECEASED
26. SIGNATURE OF NEXT OF KIN
27. SIGNATURE OF CLERGYMAN
28. SIGNATURE OF BURIAL OFFICIAL
29. SIGNATURE OF INTERVIEWER
30. SIGNATURE OF DECEASED
31. SIGNATURE OF NEXT OF KIN
32. SIGNATURE OF CLERGYMAN
33. SIGNATURE OF BURIAL OFFICIAL
34. SIGNATURE OF INTERVIEWER
35. SIGNATURE OF DECEASED
36. SIGNATURE OF NEXT OF KIN
37. SIGNATURE OF CLERGYMAN
38. SIGNATURE OF BURIAL OFFICIAL
39. SIGNATURE OF INTERVIEWER
40. SIGNATURE OF DECEASED
41. SIGNATURE OF NEXT OF KIN
42. SIGNATURE OF CLERGYMAN
43. SIGNATURE OF BURIAL OFFICIAL
44. SIGNATURE OF INTERVIEWER
45. SIGNATURE OF DECEASED

BUREAU V. S.

NOV 21 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10895 **CERTIFICATE OF DEATH**

10915

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Harvre de Grace</i>		<i>12 yrs.</i>		TOWN <i>Harvre de Grace</i>		<i>24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>847 Erie Street</i>				STREET ADDRESS (If rural give location) <i>847 Erie Street</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Mary V. Williams</i>				<i>11 - 25 1955</i>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<i>Female</i>		<i>Negro</i>		<i>Married</i>		<i>5-10-1871</i>	
						9. AGE last birthday <i>84</i> yrs.	
						IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Housewife</i>						<i>Baltimore County, Md.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Sconion</i>				<i>Sarah E. Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>no</i>		<i>Mr. Joshua C. Williams - 847 Erie St. Harvre de Grace</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE (A) <i>Uremia</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Hypertensive Cardiovascular disease</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/24</i> , 19 <i>53</i> , to <i>11/24</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11/24</i> , 19 <i>55</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>George T. Stansbury, M.D.</i>				ADDRESS (Street, city, town, state) <i>569 Revolution St. Harvre de Grace, Md.</i>			
				DATE SIGNED <i>11/26/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>11-28-55</i>		<i>Union Methodist Cemetery</i>		<i>Aberdeen, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Nov 27-1955</i>		<i>G. L. Lewis M.D.</i>		<i>Otelia J. Bullock-Harvre de Grace, Md.</i>			

BUREAU V. S.

SSCI 86 ABN-

RECEIVED